Community Hospital Task Force II
Meeting #9 Notes
April 28, 2008
Rhode Island Department of Administration
Conference Room A, 1 Capitol Hill, Providence

Community Hospital Task Force co-chair Christopher Koller opened the meeting by describing the work that has progressed since the March 11th meeting of the Task Force. A small workgroup convened twice in April to prepare additional recommendations for the Task Force to consider.

He then introduced one of the Task Force sub-group members, Lou Giancola, to present the sub-group's recommendations.

Mr. Giancola stated that the sub-group was a reflection of the larger Task Force, in that it was hard for the members to reach consensus. For example, the issue of financial and payment transparency was problematic for the payers and others. The compromise recommendation posed by the subgroup incorporates a recommendation that helps the Office of the Health Insurance Commissioner (OHIC) ensure fair treatment of providers, and asks the Department of Health to spend more resources on reports about the financial health of hospitals.

On the issue of health planning, Mr. Giancola commented that the recommendation is to work on it. On the issue of community hospital stabilization and transformation, the recommendation reflects the ambivalence of hospitals (do they want a state team interfering?) and of the state (does the state want to have to interfere?) and of the payers (do they want to pay for it?) The compromise recommendation allows hospitals to involve the state if they are struggling.

Another sub-group member, Jim Purcell, added that there are resource issues related to health planning. An ongoing question has been who will be there to enforce a health plan? Who has the authority? These discussions were also held at the Coordinated Health Planning Advisory Committee.

With regard to transparency, Mr. Purcell commented that he is against full transparency because it would be inherently inflationary. However, he noted that transparency is inevitable in some form or another. He is not against all forms of transparency, but noted that there would have to be a thoughtful approach to increasing financial and payment transparency so that it did not result in an increase in costs. Mr. Purcell further noted that there is something new in the recommendation that OHIC look at the payers' rates to hospitals – it starts the ball rolling.

Mr. Purcell also commented on the recommendation regarding the "stabilization team." He said hat it isn't that payers don't want to pay, but that there needs to be systematic changes as well. He said that he would be willing to consider the underlying principles of reimbursement – such as whether community hospitals are entitled to a specific margin. There is a role for the payer, and BCBSRI has stepped up at times. Mr. Purcell underscored that this recommendation is one he could support.

Another participant commented that he would like to see hospital financial information updated more frequently than annually – those reports could be standardized, even if hospitals were estimating their costs.

He further commented that nowhere is the goal stated that a minimum state of financial health should be required from hospitals – even as this is the goal that the Task Force should be working towards.

Dr. David Gifford stated that within the statute for licensure, the Department of Health has broad authority – but monitoring financial health is not specified in regulation. If you don't meet requirements for financial health, what are the actions the Department would take? Revoke the hospital's license? Understanding what the steps would be would be helpful – understanding that since the state is not rate-setting, the Department couldn't control payment rates to hospitals.

Mr. Koller asked if anyone had specific language to add.

Another Task Force member stated that the Task Force members are there because they don't believe the system is as efficient as it could be. The question is how hospitals can most efficiently serve Rhode Islanders now and in the future. Transparency and stabilization are necessary parts of this goal. We don't focus on how we should get there – there needs to be some incentive for the Health Planning Council to determine whether we need all the facilities we have now. He concluded by saying that the state can't answer questions of transparency and stabilization without planning (and enforcement of planning) – and planners need to make sure that hospitals support at least some of the plan.

A different Task Force member stated that because community hospitals are distressed, and still efficient and low-cost, there's no solution that won't cost someone some money. These documents take a pass at that issue. There's a recommendation in the full Task Force report for no change in the current private negotiation process – how can the Taks Force support that? He stated his disappointment that the Task Force didn't go further.

The discussion continued, with the comment made that the central recommendation that the state have oversight of payment rates is substantial. Another comment was that the report shouldn't say that the reimbursement system shouldn't be changed – just that we don't know how to change it. A suggestion was made to compile how payers pay hospitals by procedure – does the state have the authority to get that information? Mr. Koller said yes, in the insurance examination statute – can't get it from hospitals, but can get it from insurers.

Another Task Force member noted that if insurers' resources get below a certain level, regulatory activities are initiated – and insurers go into receivership. What do we do now when community hospitals are in trouble? Do we devise a regulatory framework to stabilize until payers decide what to do? The fundamental problem is that commercial payers are the only entities who can pay, but they only have 25-35% of hospital patients.

Another Task Force member questioned whether it was good public policy that the state or community would only act if a hospital has used all of its resources – that would dampen fundraising efforts.

One Task Force member suggested that instead of supporting the current private negotiation process, there needs to be change towards more oversight. An insurer representative to the Task Force commented that there is a fear of going to a completely regulated model and still maintain affordability. Could accept a recommendation that states that there is dissatisfaction with results of current process.

Another Task Force member suggested that we add language that states that the payment system should reinforce the desired outcome of the health care system – access, quality, efficiency, and distribution of services.

The Task Force then turned to the issue of hospital stabilization. The comment was made that hospitals would design a short-term plan with a stabilization team – and that this process would have to be voluntary, because it's the hospital Board's responsibility to maintain fiduciary responsibility. Other Task Force members commented that it was unclear what "public policy modifications" members of the stabilization team would effectuate – perhaps it should read "determine appropriate actions."

The Task Force then discussed the recommendations regarding transparency. A member raised the concern that it was unclear what would be done with newly-transparent information. Another member connected it back to the same issue as planning – where's the enforcement? The recommendation was made to add that oversight would be "consistent with their statutory responsibilities" (to cover what actions are possible as a result of oversight.)

Some Task Force members then raised the issue of the increased taxes on community hospitals proposed in the next state fiscal year budget. Discussion continued as to whether a recommendation against those increased taxes should be in the CHTF report. The decision was made by some Task Force members to draft a letter regarding the taxes, to mention it in the transmittal letter to the report, and include it as a recommendation in the report.

Another Task Force member raised the question again – where is the enforcement of any health plan that would be created? Others around the table mentioned that the Health Services Council enforces Certificate of Need decisions, the legislature requires an annual report, and the payers sit on the health planning council and make decisions about payment that hopefully would support the plan they adopt.

Mr. Koller then opened the discussion of the format for the report. Should recommendations about Medicaid be included? One Task Force member pointed out that it was part of the charge, so they should be presented along with these additional recommendations. Another Task Force member raised a concern about Medicaid payment methodology and how it was developed in regulations. A suggestion was made to state in the report that Medicaid payment methodology is best left to be developed by the Department of Human Services and the hospitals, and that it should minimize the adverse impact to community hospitals.

A Task Force member stated that he doesn't feel that the Task Force accomplished anything – all he has heard is that the hospitals do not want to be harmed.

A motion was put forward to have the draft report include only recommendations, no findings. All but one member agreed.

The process was then reviewed: A sub-set of Task Force members volunteered to review the next draft of the report, before it went to the whole Task Force for approval.

<u>Public comment</u>

Ed Quinlan from the Hospital Association of Rhode Island stated that HARI had put forward a motion to remove recommendations about Medicaid, and is surprised to see that those recommendations will remain in the report. He further stated that a year ago, the Task Force recommended budget neutrality, but now, if the proposed budget is approved, it will hurt community hospitals.